

055127

FOR
STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06416
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2d. HOUR	
Janet Fay Arnold								2-10-86								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	Cauc.	Feb. 5. 1942		44 YRS.						2-10-86						10PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
New Jersey		U.S.A.				Worcester County											
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Ocean City		719-142 St. Apt. 235-B		Receptionist		Resort											
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Worcester		Ocean City		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21842 719 142 St. Apt 235-B									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Arthur Whitmore, Jr.		Lois King															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. (FATHER) ADDRESS													
no		146-32-4140		Mr. Arthur Whitmore, Jr. Port Richey Fla. 33568													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Seizure disorder											
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)		DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Margarita A. Korell, M.D.		M.D. Assistant		2-10-86													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
		111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		2/15/86		Grace Mem. Gardens		Hudson Pasco Fla.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
E. Barnes		21018		FEB 19 1986													
Fleming Funeral Service		Benson, Md.															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN THIS COPY FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

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055114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

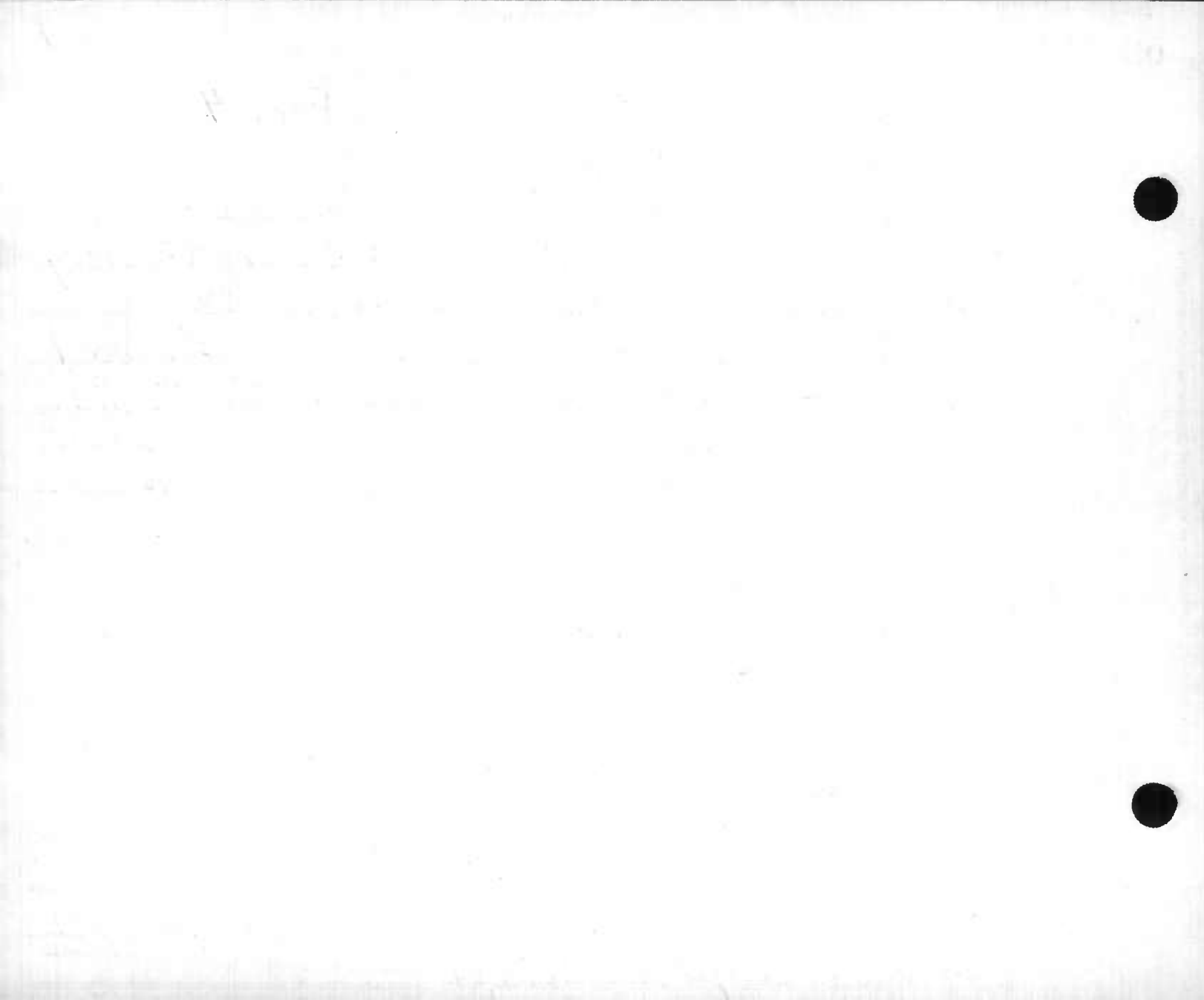
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 06417

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Isiah</u> <u>Belote</u>			2a. DATE OF DEATH MONTH <u>Feb.</u> DAY <u>4</u> YEAR <u>1986</u>			2b. HOUR M					
3. SEX <u>Male</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH MONTH <u>Aug.</u> DAY <u>10</u> YEAR <u>1915</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u> YRS.		6. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		6. IF UNDER 24 HRS HOURS <u></u> MIN <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Worcester</u> MD.					
10. CITY OR TOWN OF DEATH <u>Pocomoke</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Home - Rural</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Laborer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>			
13a. STATE <u>Md.</u>			13b. COUNTY <u>Worcester</u>		13c. CITY OR TOWN <u>Pocomoke</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>PO Box 353 21857</u>		
14. FATHER'S NAME FIRST <u>Fred</u> MIDDLE <u></u> LAST <u>Belote</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Hester</u> MIDDLE <u></u> LAST <u>Bagwood</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>			16b. SOCIAL SECURITY NO. <u>229-07-6770</u>		17. INFORMANT ADDRESS <u>Rt. 2 Bx. 395 - Pocomoke, Md.</u> <u>Winnie G. Belote</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR TACHYCARDIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AD. DM.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u> <u>10 YEARS</u> <u>30 YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>ASTHMA HBP</u>											
19a. DATE OF OPERATION <u>MA</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>MA</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>7/5</u> 19 <u>80</u> to <u>2/3</u> 19 <u>86</u> , that (2) (we) last saw the deceased alive on <u>2/3</u> 19 <u>86</u> , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) (did) (not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u> MD						22c. DATE SIGNED <u>2/5/86</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RITCHIE C. SHOEMAKER MD</u>						22f. ADDRESS <u>PO Box 25 Pocomoke MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>2-9-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sinai Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Pocomoke Worcester Md.</u>				
24. FUNERAL DIRECTOR NAME <u>Daniel H. Savage</u> ADDRESS <u>New Church, Va.</u>						25a. DATE REC'D. BY REGISTRAR <u>FEB 19 1986</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

BP



052122

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

06418

REG. NO

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Charles William Birch		2a. DATE OF DEATH MONTH DAY YEAR 02 09 86		2b. HOUR M AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 01 26 1904	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD	
10. CITY OR TOWN OF DEATH Ocean City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9004 E. Biscayne Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired from	12b. KIND OF BUSINESS OR INDUSTRY E.S. Adkins Co
13a. STATE Maryland	13b. COUNTY Worcester	13c. CITY OR TOWN Ocean City	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Charles W. Birch	15. MOTHER'S MAIDEN NAME Sallie Hall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-12-6886	17. INFORMANT NAME ADDRESS Charles D. Birch, 36 S. Main St., Camden, DE 19934		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2-9 , 19 86 , to 2-10 , 19 86 , that (I) (we) lost saw the deceased alive on 2-10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Wilber Ellis, Jr.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-10-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilber Ellis, Jr., M.D.	22e. ADDRESS 100 Power St., Salisbury, MD 21801			
23a. BURIAL, CREMATION, REMOVAL METHOD Burial	23b. DATE 2/11/86	23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Worcester MD	
24. FUNERAL DIRECTOR NAME ADDRESS W. Kirk Burbage, 108 Williams Street Berlin, MD 21811				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of a death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the folder with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

021520

REPT NO 100 202

OVER WINTERED

065184

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 6 4 1 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WOODROW W. BLOXOM			2a. DATE OF DEATH MONTH DAY YEAR February 20, 1986		2b. HOUR M AM
3 SEX male	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR March 14, 1914	6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.		
10. CITY OR TOWN OF DEATH Pocomoke	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1314 Dorchester Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired NASA		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Worcester	13c. CITY OR TOWN Pocomoke	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1314 Dorchester Street
14. FATHER'S NAME FIRST MIDDLE LAST Clairville W. Bloxom		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Cutler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW2		17. INFORMANT Ruth Bloxom ADDRESS 1314 Dorchester Street Pocomoke City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE COPD DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC BRONCHITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) VENTRICULAR ARRHYTHMIA					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from 1980 , 19____, to 2/20 , 19 1986 that (b) (we) last saw the deceased alive on 2/14/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (and) (did not) view the body after death.					
22b. SIGNATURE RC Stobbeneken MD		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RC Stobbeneken MD		22e. ADDRESS Po Box 25 Pocomoke MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/22/86		23c. NAME OF CEMETERY OR CREMATORY Cem. Temperanceville Acc. Va.	
24. FUNERAL DIRECTOR NAME Scott S. Melan		ADDRESS Pocomoke City, Md.		25a. DATE REC'D. BY REGISTRAR FEB 28 1986	
25b. REGISTRAR'S SIGNATURE John L. Henderson					

042063

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 06420

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
FIRST MIDDLE LAST ELLA - A. BRATTEN			MONTH DAY YEAR 2 2 86			7:18PM			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		BLACK		MONTH DAY YEAR 2 9 21		64 YRS		IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		USA				WORCESTER MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BERLIN		BERLIN NURSING HOME				HOUSEWIFE		-	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE	
MARYLAND		WORCESTER		BISHOPVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RTL, BOX 280 21813	
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Louis Townsend					FIRST MIDDLE LAST Estella Collins				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		
NO					214 12 5625		Maggie Blake, Rt. 1 Box 280, Bishopville, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alzheimer's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-25</u> 19 <u>83</u> , to <u>Feb</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Jan-29</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
<u>Federico Arthes</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			2-2-86-	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
FEDERICO ARTHES, MD					3 BAY STREET, BERLIN, MD. 21811				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			2/8/86		Curtis Cemetery		Bishopville, Md.		
24 FUNERAL DIRECTOR (NAME)					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
<u>Richard T. Watson</u>					FEB 05 1986 <u>John Davidson-Randall</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Louis Townsend

Charles Collins

Charles Collins, Jr. 1 son 250, also 14.

Charles Collins, Jr.

Charles Collins, Jr.

Charles Collins, Jr.

Charles Collins, Jr.

062061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 6 4 2 1
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2. DATE OF DEATH		2b. HOUR	
IDA MAE SHOCKLEY DALE				2 21 86		4:15 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		NEGRO		MONTH DAY YEAR 11 06 02		83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				WORCESTER MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
SNOW HILL		RT.#2, SHOCKLEY ROAD		RETIRED		HOUSEWIFE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS	
MARYLAND		WORCESTER		SNOW HILL		Rt. #2, Box 55, Shockley Road	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
ALFRED SHOCKLEY		RENNIE HARMON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		215-36-0365		Ollie Blake		same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gangrene</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Ben Meyer		MD		2/24/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Benjamin Meyer, MD.		560 Riverside Dr., Salisbury, MD 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		3/01/86		Friendship U.M. Ceme.		Snow Hill Worcester MARYLAND	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOLLEY MEMORIAL CHAPEL		Rt. #2, Jersey Rd. SALISBURY, MD.		FEB 27 1986		Julia Davidson-Rendall	

052141

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 6 4 2 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Raymond Lee Dennis			2a. DATE OF DEATH MONTH DAY YEAR 02 09 86		2b. HOUR M AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 04 19 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH W. Ocean City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Box 320B		12a. USUAL OCCUPATION (TYPE OF WORK FOR 15 OF WORKING LIFE) theater manager & electrician	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Worcester	13c. CITY OR TOWN W. Ocean City	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George Clarence Dennis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella May Davis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII	17. INFORMANT ADDRESS Bob Taylor, Ocean City, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC BRAIN DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CORD					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 2/1 , 19 85 , to 2/9 , 19 86 , that (I) (we) last saw the deceased alive on 2/1 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William H. Robins		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William H. Robins, M.D.		22e. ADDRESS Rt. 50 & Civic Ave., Salisbury, MD 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/12/86	23c. NAME OF CEMETERY OR CREMATORY Franklin Cemetery	23d. LOCATION CITY OR TOWN COUNTY Greenbackville VA.		
24. FUNERAL DIRECTOR NAME W. Kirk Burbage		108 Williams Street Berlin, MD 21811		25a. DATE REC'D. BY REGISTRAR EB 14 1986	25b. REGISTRAR'S SIGNATURE John A. Davidson

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

044038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 6 4 2 3
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eldridge Farren			2a. DATE OF DEATH MONTH DAY YEAR 2 3 86			2b. HOUR 8:30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 6 11		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH Berlin		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Berlin Nursing Home, Berlin, MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	
12b. KIND OF BUSINESS OR INDUSTRY Poultry							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY Worcester		13c. CITY OR TOWN Showell		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE P.O. Box 1, Showell, MD 21862							
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Henry Farren				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Crowder Farren			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233-28-2072		17. INFORMANT ADDRESS Elle M. Murphy W. Mt. Vernon St. Smyrna, De. 19977			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) ASOB. CUR - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) Age							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12-5 84 2-3 86			
22a. I certify that (I) (this hospital) attended the deceased from Feb 3 1986 to 2-3 1986 that (I) (we) lost saw the deceased alive on Feb 3 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-3-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Federico Arthes				22e. ADDRESS 3 Bay Street, Berlin, MD 21811			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/6/86		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Smyrna, Delaware	
24. FUNERAL HOME TO BE USED NAME Faries Funeral Dir.		25. ADDRESS S. Main St. Smyrna, Del. 19977		26. DATE REC'D. BY REGISTRAR 1000		27. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

BP

074038

GREEN COTTON LINES

WINTER



071076

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 6 4 2 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lawrence Edward Gordy			2a. DATE OF DEATH MONTH DAY YEAR February 27, 1986		2b. HOUR A 12:05 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 24, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH Snow Hill	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 104 N. Bay Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY House
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Worcester	13c. CITY OR TOWN Snow Hill	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST L. Welton Gordy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Parsons		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 220 12 2009		17. INFORMANT ADDRESS Pauline D. Gordy, Snow Hill, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYO CARDIAC INFARCTION					11 HRS
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 27 , 19 86 , to FEB 27 , 19 86 , that (I) (we) last saw the deceased alive on FEB 27 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert C. La Mar		DEGREE M.D.		22c. DATE SIGNED 2-28-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT C. LA MAR, M.D.		22e. ADDRESS 104 N. Bay St, Snow Hill, Md. 21863			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/1/86	23c. NAME OF CEMETERY OR CREMATORY Bates Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Snow Hill, Maryland	
24. FUNERAL DIRECTOR NAME Norman F. Dennis,		ADDRESS Snow Hill, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 04 1986	

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

071199

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 6 4 2 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harold C Hall			2a. DATE OF DEATH MONTH DAY YEAR 02 19 1986		2b. HOUR 5:45p.m.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 02 09 1900		6. AGE (IN YEARS, LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH Pocomoke City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartley Hall Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Civil Service	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Virginia	13b. COUNTY Accomac	13c. CITY OR TOWN Chincoteague	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 132 Mumford Street 23336	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas E Hall	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Kuntzman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 231261020		17. INFORMANT ADDRESS Edith Hall, Chincoteague, Virginia			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Parkinson's Disease		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 07-25 19 85 to 02-19 19 86, that (I) (we) last saw the deceased alive on 02-17 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we did not view the body after death).			
22b. SIGNATURE Robert B. Allen	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 02-20-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert B. Allen	22e. ADDRESS 305 10th St., Pocomoke City, Md. 21851		

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 2-23-86	23c. NAME OF CEMETERY OR CREMATORY John Taylor Cemetery	23d. LOCATION Temperanceville, Virginia
24. FUNERAL DIRECTOR Gene S. Salyer		25a. DATE REC'D BY DEPT. CLERK FEB 26 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson-Podder

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

071193

W. J. Taylor

John Taylor

John Taylor

065190

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 6 4 2 6
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ANNIE OLDHAM LEWIS			2a. DATE OF DEATH MONTH DAY YEAR 2 18 1986			2b. HOUR 5:30 P.M.		
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 10 8 96		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.			
10. CITY OR TOWN OF DEATH BERLIN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEL. OPER.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE VIRGINIA		13b. COUNTY ACCOMAC	13c. CITY OR TOWN TEMPERANCE-	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 23442 99999		
14 FATHER'S NAME FIRST MIDDLE LAST EDWARD S. OLDHAM		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH TURNER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 227 05 3597		17 INFORMANT ADDRESS Mrs. Nicholas Carter Atlantic, Virginia 23303				

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiac Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above), (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Mark B. m		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 2-18-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK BAFFUM M.D.		22e. ADDRESS Rt. 3 Box 12 A Berlin, Md. 21811			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/21/86	23c. NAME OF CEMETERY OR CREMATORY Parksley Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Parksley Accomack Va.
24 FUNERAL DIRECTOR (NAME) John J. Williams		25a. DATE REC'D. BY REGISTRAR FEB 25 1986	
25b. REGISTRAR'S SIGNATURE John J. Williams			

DHHM - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

065130

OLDHAM



CADAM

OLDHAM

EDWARD

RECEIVED NOV 10 1963

WILLIAM

The Nicholas Center, Atlantic, Virginia 23203

initial

WOLFE

Project Director

Project

Yakovlev

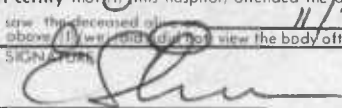

Box 127
Perryville, Va.
22850

049128

#17, per F.H. 2/20/86 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8606427
REG. NO.FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William H. Peters			2a. DATE OF DEATH MONTH DAY YEAR February 11, 1986		2b. HOUR 6:45^a								
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 02 1921		6. AGE (IN YEARS LAST BIRTHDAY) 65		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER							
10. CITY OR TOWN OF DEATH BERLIN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 389 OCEAN PKWY - OCEAN PINES				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Supervisor			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland				13b. COUNTY Worcester		13c. CITY OR TOWN Berlin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 389 Ocean Parkway Berlin, Md. 21811			
14. FATHER'S NAME FIRST MIDDLE LAST John H. Peters				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora 1. Harløy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17. INFORMANT Alberta W. Winterling Peters		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) lung carcinoma - metastatic DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 11/7 , 19 85 , to 2/11 , 19 86 , that (1) (we) lost 11/7 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we could not view the body after death, so state.)													
22b. SIGNATURE 				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/11/1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Charles Silvia				22e. ADDRESS 540 Riverside Drive, Salisbury, Md. 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-14-86		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith				23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto., MD			
24. FUNERAL DIRECTOR NAME John C. Miller Funeral Home				25a. DATE SIGNED BY REGISTRAR 6415 Belair Rd. 21206 FEB 13 1986				25b. REGISTRAR'S SIGNATURE 					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed in the funeral home after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 6 4 2 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William T. Rogers			2a. DATE OF DEATH MONTH DAY YEAR Feb. 16, 1986			2b. HOUR 12 ²⁰ A.M.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3-8-27		6. AGE (IN YEARS LAST BIRTHDAY) 58		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.				
10. CITY OR TOWN OF DEATH BERLIN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DENT TRAPPE RD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DRIVER		12b. KIND OF BUSINESS OR INDUSTRY CONST.		
13a. STATE MD			13b. COUNTY WOR		13c. CITY OR TOWN BERLIN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS BOX 4 - TRAPPE RD, 2811	
14. FATHER'S NAME FIRST MIDDLE LAST ORVILLE COOPER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE A. ROGERS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II 218-20-7741		17. INFORMANT ADDRESS LOIS ROGERS, BERLIN, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Stomach</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 15, 1985</u> to <u>Feb. 16, 1986</u> , that (I) (we) last saw the deceased alive on <u>Jan. 28, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>James E. Martin, M.D.</u>						DEGREE M.D.		22c. DATE SIGNED 2/17/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Martin, M.D.						22e. ADDRESS 1300 S. Division St., Salisbury, M.D.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-19-86		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN, WOR, MD.				
24. FUNERAL DIRECTOR NAME VLLRICH F.H. BERLIN, MD.						25. DATE REC'D. BY REGISTRAR FEB 20 1986				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REAR (REV)

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REAR (REV)

055113

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP _____
DHMH - 17
(VR A15 ME (S))FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 06429

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gregory D. Schoolfield			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <input checked="" type="checkbox"/> 2 7 1986		2b. HOUR 0020
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 13 60	6. AGE (IN YEARS) (LAST BIRTHDAY) 25 YRS.	IF UNDER 1 YR. MONTHS DAYS 25	IF UNDER 24 HRS. HOURS MIN. 25
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Showell		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 113 at Jarvis Road		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Worcester		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Schoolfield, Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geraldine Johnson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 214-76-2342		17. INFORMANT ADDRESS Charles Schoolfield, Jr. Rural Pocomoke, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 0020 2 7 1986		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 0020 2 7 1986			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) auto struck by truck		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt 113/Jarvis Rd, Showell, Worcester, Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John G. Bulkeley		TITLE (SPECIFY) Deputy		DATE SIGNED 2-13-86	
EXAMINER'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D.		ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-15-86		23c. NAME OF CEMETERY OR CREMATORY St. James Cem.	
24. FUNERAL DIRECTOR NAME Samuel H. Savage		ADDRESS New Church, Va.		25b. DATE REC'D BY REGISTRAR FEB 19 1986	

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1. The first part of the report is a description of the project. It is a study of the effect of the new drug on the disease. The study was conducted in a hospital and involved 100 patients. The patients were divided into two groups: one group received the new drug and the other group received a placebo. The results of the study showed that the new drug was effective in treating the disease. The second part of the report is a discussion of the results. It discusses the limitations of the study and the need for further research. The third part of the report is a conclusion. It states that the new drug is a promising treatment for the disease and that further research is needed to confirm these findings.

045006

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 6 4 3 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katharine Schwartz			2a. DATE OF DEATH MONTH DAY YEAR 1-31-86		2b. HOUR 12:20P					
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2-15-03		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.				
10. CITY OR TOWN OF DEATH Berlin		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Berlin Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bank Teller		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY Worcester		13c. CITY OR TOWN Ocean City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6801 Atlantic ave. 21842	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leach							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-24-3597		17. INFORMANT Annette Dealond		ADDRESS 2921 Edgewood Ave. Balto., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MI DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASVD DUE TO, OR AS A CONSEQUENCE OF (c) HYG								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Jan 84 , 19 86 , to Jan 86 , 19 86 , that (I) (we) last saw the deceased alive on Jan 31 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. Federico Arthes, MD				DEGREE		22c. DATE SIGNED 2-1-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Federico Arthes, MD				22e. ADDRESS 3 Bay Street, Berlin MD 21811						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1/31/86		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR FEB 13 1986		25b. REGISTRAR'S SIGNATURE Davidson-Randall		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Aceto
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200% COTTON

James M. ...

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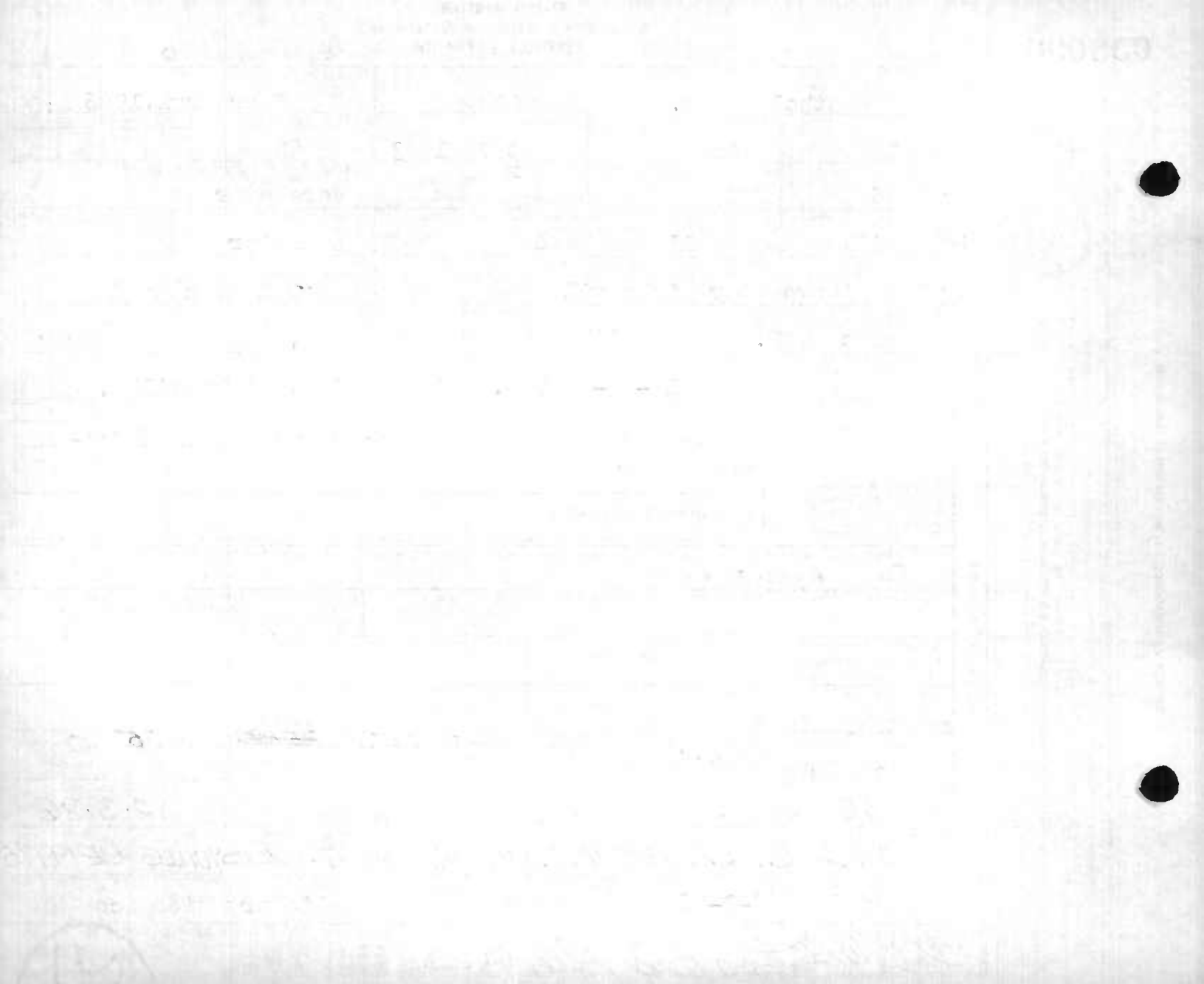
038036

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		8 6 REG. NO. 0 6 4 3 1											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR AM			
Ethel		A.		Smith				February 1, 1986		4:00 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female		White		August 7 1903		82 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Worcester MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bishopville		Campbelltown Road						Homemaker		2812			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Worcester		Bishopville				Campbelltown Road					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Isaac B. Smith				Hannah Murray									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No				218-48-5927		J. Oliver Smith, Bishopville, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Ess. hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
				1-FEB 1986									
22a. I certify that (this hospital) attended the deceased from <u>22 MARCH 1965</u> to <u>1-FEB 1986</u> , that (we) lost saw the deceased alive on <u>25/NOV 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.										22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
JACK C. LEWIS, M.D.										2.3.86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
JACK C. LEWIS, M.D.		15 Williams St. SELBYVILLE DE 19975											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		2-3-86		Parsons		Salisbury Wicomico MD							
24. FUNERAL DIRECTOR, NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE							
Charles W. Smith, Selbyville, Delaware						FEB 05 1986 General Davidson - Hordell							



062007

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 0 6 4 3 2

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Jearlena		Taylor		Feb. 11, 1986		2:25 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female	Black	July 22, 1939		46 YRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Virginia	USA			Worcester MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Pocomoke	Home			Domestic		House wife	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.	Worcester	Pocomoke		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		902 2nd. Street 21851	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Hezekiah Fletcher				Mattie Laws			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		228-48-5702		Charles Taylor-902 2nd. St.-Pocomoke, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>multiple myeloma advanced</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>with Bleeding diathesis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Pathologic Fractures</i> DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Hypertension</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<i>Helen M. Baldado</i>						2-13-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
		Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		2-16-86		First Baptist		Mappsville Accomack, Va.	
24 FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<i>Keith E. H. Wharton</i> - Accomack, Va. 23301				FEB 27 1986		<i>Julia Davidson-Rendell</i>	

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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

1. The first part of the document is a letter from the Director of the Federal Bureau of Investigation to the Director of the Central Intelligence Agency. The letter is dated 10/10/50 and is signed by J. Edgar Hoover. The subject of the letter is the "Security of the Central Intelligence Agency." The letter discusses the need for the Central Intelligence Agency to have a high level of security and to be able to handle confidential information. It also discusses the need for the Central Intelligence Agency to have a high level of loyalty and to be able to handle confidential information. The letter is a memorandum for the Director of the Central Intelligence Agency and is signed by J. Edgar Hoover.

2. The second part of the document is a letter from the Director of the Federal Bureau of Investigation to the Director of the Central Intelligence Agency. The letter is dated 10/10/50 and is signed by J. Edgar Hoover. The subject of the letter is the "Security of the Central Intelligence Agency." The letter discusses the need for the Central Intelligence Agency to have a high level of security and to be able to handle confidential information. It also discusses the need for the Central Intelligence Agency to have a high level of loyalty and to be able to handle confidential information. The letter is a memorandum for the Director of the Central Intelligence Agency and is signed by J. Edgar Hoover.

041137

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

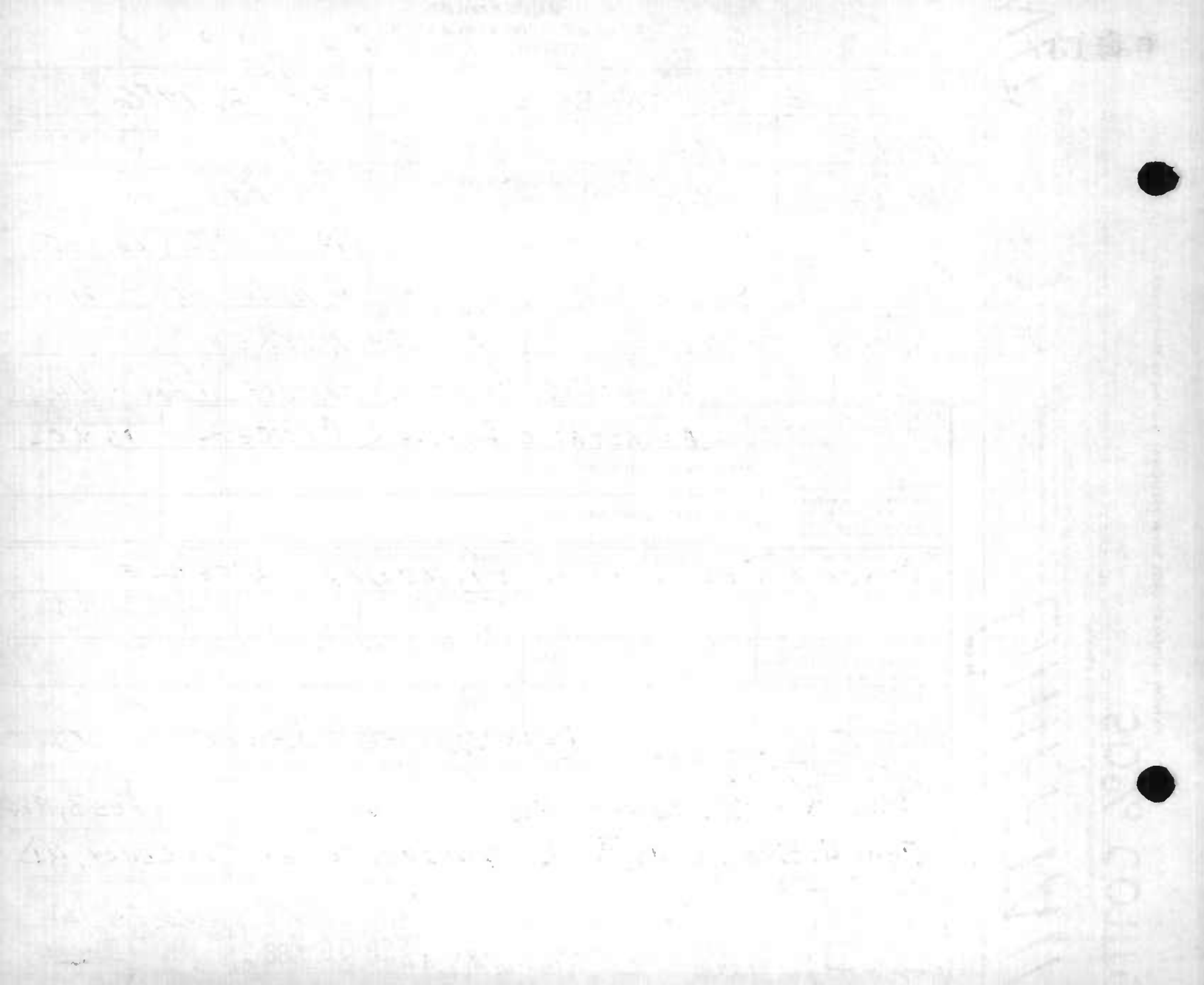
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) JUNE H. TRIMBLE									
2a. DATE OF DEATH MONTH FEB DAY 2 YEAR 1986									
2b. HOUR M									
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH 1 DAY 22 YEAR 15		6. AGE (IN YEARS LAST BIRTHDAY) 71		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.			
10. CITY OR TOWN OF DEATH BERLIN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. MAIN ST. EXT				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONST.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY WOR		13c. CITY OR TOWN BERLIN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS N. MAIN ST. 21811	
14. FATHER'S NAME FIRST RALPH MIDDLE TRIMBLE LAST TRIMBLE					15. MOTHER'S MAIDEN NAME FIRST LAURA MIDDLE MOORE LAST MOORE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 26-18-2566		17. INFORMANT ADDRESS CLARA W. TRIMBLE BERLIN, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BLADDER CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MOS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from DECEMBER 82 to PRESENT , 19 85 , that (1) (we) lost saw the deceased alive on OCTOBER 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we both did not view the body after death, so state.)									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN H. SHENASKY MD				22c. DATE SIGNED FEB 3, 1986				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (CHECK) CREMATION		23b. DATE 2-3-86		23c. NAME OF CEMETERY OR CREMATORY DEL MARVA CR.		23d. LOCATION CITY OR TOWN LEWES, SUSSEX, DEL COUNTY STATE			
24. FUNERAL DIRECTOR (NAME) ULRICH F.H.				25. DATE REC'D. BY REGISTRAR FEB 06 1986				25a. REGISTRAR'S SIGNATURE [Signature]	
24. ADDRESS BERLIN, MD.				25b. REGISTRAR'S SIGNATURE [Signature]					



045044

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH6 06434
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Andrew F Wiegand Jr.			2a. DATE OF DEATH MONTH DAY YEAR 2 6 86		2b. HOUR 6:00AM						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 3 23		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester County MD.					
10. CITY OR TOWN OF DEATH Ocean City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13520 Holly Lane (Home)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fireman			12b. KIND OF BUSINESS OR INDUSTRY Balto City		

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland				13b. COUNTY Worcester		13c. CITY OR TOWN Ocean City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13520 Holly Lane 21842			
14. FATHER'S NAME FIRST MIDDLE LAST Andrew F. Wiegand Sr				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Hadaway									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				16b. SOCIAL SECURITY NO. 218-18-9082				17. INFORMANT Clara Rose Wiegand				ADDRESS Same as 13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Min</u>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 vessel coronary artery disease</u>		<u>4K</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>		<u>9</u>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Emphysema

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> , 19 <u>86</u> , to <u>10/6</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>10/6</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John Green</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/10/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Green MD		22e. ADDRESS Locust & Quincy Sts, Salisbury Md 21801					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/10/86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md	
---	--	----------------------	--	---	--	---	--

24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR FEB 11 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

2025 COLLECTION

066157

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 06435

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
EDGAR LEE WILKERSON				February 12, 1986		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
male		white		Dec. 2, 1914		71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		USA				Worcester MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Pocomoke		Route #3, Box 370		retired Farmer			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Worcester		Pocomoke		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		21851	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		Route #2, Box 370			
William E. Wilkerson		Manie Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		215-36-1615		Emily T. Wilkerson		Route #2, Box 370 Pocomoke City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
				75		11/19/85	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/19/85</u> to <u>11/19/85</u> , that (I) <u>was</u> lost saw the deceased alive on above, (I) <u>was</u> and (I) did not view the body after death, and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		2/16/86		Pitts Creek Pres. Cem.		Pocomoke Worcester Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		FEB 24 1986		25b. REGISTRAR'S SIGNATURE	
Scott S. Melsen		Pocomoke City, Md.				John Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caption papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

